418 - PROVIDER AND AFFILIATE ADVANCE REQUEST POLICY

Original Date: 1/31/08
Effective Date: 10/01/08
Revision Date: 1/31/08

Staff responsible for policy: DHCM Operations (Acute Care and ALTCS)

I. Purpose

This policy applies to the Acute Care and ALTCS Contractors. The policy establishes the procedure for Contractor approval or notification to AHCCCS of provider and affiliate advances as required by Section D, Paragraph 49 of the Acute Care Contract and Section D, Paragraph 50 of the Arizona Long Term Care System (ALTCS) Contract.

II. For purposes of this policy definitions are as follows:

Affiliate (Related Party Transactions): Transactions with a party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by the Contractor. Control, for purposes of this definition, means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an enterprise through ownership, by contract, or otherwise. "Related parties" or "Affiliates" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

Advance: Includes but is not limited to payment to a provider by a Contractor which is based on an estimate of received but unpaid claims (RBUCS), an estimate of the value of erroneous claim denials (including underpayments), or as otherwise defined by the Contractor.

Day: Calendar day unless otherwise specified.

Provider: Any person or entity who submits a claim and receives payment for the provision of covered services to members according to the provisions of A.R.S. § 36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. § 36-2901. For the purposes of this policy, a Provider shall be further defined as all individuals associated by the same Tax Identification Number, utilized for claiming purposes.

III. Policy

A. Provider Advances

The Contractor shall submit written notification of any cumulative advance equal to or in excess of $50,000 per provider Tax Identification Number (TIN) within a contract year. For any

individual advance equal to or in excess of $50,000 per provider Tax Identification Number (TIN) within a contract year, the Contractor must request approval from AHCCCS at least 10 days prior to disbursement of the funds. In exigent circumstances, AHCCCS may waive the 10 day notification requirement. All requests for approval must be submitted in writing to the Acute Care or ALTCS Operations and Compliance Officer in the format detailed below:

1. A detailed letter of explanation must be submitted that delineates:
    - A copy of the written communication that will serve as notification to the affected provider(s).
    - The provider(s) name(s) and AHCCCS Identification Number(s).
    - The date the provider and contractor initiated discussions relating to the need for an advance;
    - The systemic organizational causes resulting in the need for an advance;
    - The process that will be utilized to reconcile the funds against claims payments;
    - The anticipated timeline for the project ;
    - The corrective action(s) that will be implemented to avoid future occurrences; and
    - Total advance amount, and if applicable, the percentage that the advance amount is of total estimated amount that should have been paid, and range of dates (month / year) for the impacted claims.

2. Upon completion of the advance(s), AHCCCS may request that the Contractor make available within three working days a listing of the payments to be advanced, organized by provider Tax Identification Number if multiple providers are affected, that should include the following:
    - AHCCCS Member ID
    - Date of Service
    - Original Claim Number
    - Date of Payment
    - Amount Paid
    - Amount Advanced
    - Balance due to/from the provider

B. Routine/Scheduled Advances to Provider and Any Advances to Affiliates

Routine/scheduled advances to providers as a result of contractual arrangements or **any** advance to an affiliate must be submitted to AHCCCSA for prior approval. The request for approval must be submitted 30 days in advance of the effective date of the contractual arrangement or advance and 30 days prior to any amendments to contractual arrangements.

All contractual arrangements regarding routine/scheduled advances in existence at the start of new contract award resulting from a Request for Proposal must be reported to AHCCCS 15 days prior to the start of the new contract cycle.

AHCCCS may request additional information or periodic reconciliations related to these advances.

C. AHCCCS Responsibilities

All requests submitted will be reviewed by the Division of Health Care Management to evaluate the appropriateness of the Contractors plan to advance payment and resolve any future occurrences with accurate and timely claims payment. AHCCCS reserves the right to discuss any advance with the provider community to such extent as it is appropriate to determine the appropriate communication and approval action. Communication will be at the timing and discretion of AHCCCS.

DHCM will acknowledge all requests in writing through electronic mail upon receipt of the completed file. A written determination will be sent to the Contractor by electronic mail no later than 30 days from the date of receipt of all required information from the Contractor. Any request for which no response is sent within the 30 day timeframe above will be deemed approved by DHCM.

IV. References

Acute Care Contract Section D
ALTCS Contract, Section D